Department of Medical Assistance Services
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Richmond, Virginia 23219

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MEDICAID MEMO

TO: All Providers and Managed Care Organizations (MCOs) participating in the Virginia Medical Assistance Program

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services (DMAS)

MEMO Special

DATE 08/30/2006

SUBJECT: Revision of the DMAS-30 R 5/06 and DMAS-31 R 5/06 (Title XVIII) Medicare Part B Deductible and Coinsurance Original and Adjustment/Void Invoice Forms

The Department of Medical Assistance Services has revised the DMAS-30 and DMAS-31 (Title XVIII) Medicare Part B deductible and coinsurance invoice (original and adjustment/void) forms. The revised forms accommodate the Medicaid Provider Number or National Provider Identifier (NPI on 10/1/06) for both billing and rendering (servicing) providers. They also allow for capture of the National Drug Code whenever there is a Healthcare Common Procedure Coding System (HCPCS) procedure used for drugs that are provided from a physician office setting.

The implementation of the revised forms will be required for Part B paper claims **received on or after October 1, 2006.** However, do not use the revised forms before this date. Do not use any existing invoice forms that you may have remaining in your stock after this date. The only invoice form that will be accepted for claims postmarked on or after October 1, 2006, will be the DMAS-30 R 5/06 and the DMAS-31 5/06. An example of these forms and instructions for completion are attached to this memorandum. These forms are available for downloading from the DMAS website at http://www.dmas.virginia.gov. Please be mindful that the forms can only be reproduced by downloading and subsequently printing them from the DMAS website. Please **do not** Xerox copy the downloaded forms as xeroxed copies will distort their formatting. Should you wish to receive the forms that are available as 'pin-feed' (as our current DMAS 30 form), please call the DMAS Order Desk at 1-804-780-0076 or fax your order to 1-804-780-0198. Note: include your name, telephone number with area code, complete street address with the city, state and zip code.

DMAS would also like to encourage the electronic submission of Medicare Part A and Part B claims to decrease the time and effort to create the paper claim, decrease human errors and to increase the timely processing of Medicare deductible and coinsurance claims. Several reminders to assist you with enhancing the processing of your electronic claims are included as Attachment A and Attachment B.

DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov.

DMAS is in the process of updating the *Billing Instructions* chapter for each Provider Manual on the DMAS Website (to include the newly revised forms) as expeditiously as possible. Providers will be notified when the updates have been completed. In the interim, please utilize the attached forms.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr-provider_newletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.

Attachment (A)

How to Submit a Secondary Claim to Medicaid When Medicare is Primary

If you receive notification that your Medicare claim was crossed over to Medicaid, but it does not appear on a remittance advice after 30 days, you should submit the claim directly to Medicaid. In the past such a claim had to be sent on paper (UB-92 or DMAS-30), but the claim can now be sent electronically.

- For 837 I claims, send the claim as if it were a Medicaid claim (2000B current payer loop is Virginia Medicaid) and send the other payer information (i.e., Medicare) in the 2320 other payer loop. The AMT segments in the Medicare 2320 other payer loop are used to report Medicare adjudication results. If the claim was adjudicated at the claim level then claim level CAS segments should be used to report Medicare coinsurance and deductible amounts. If the claim was adjudicated at the service line level then use the service line level CAS segments. CAS segment amounts may be reported at the claim level or service line level but not both.

- For 837 P claims, send the claim as if it were a Medicaid claim (2000B current payer loop is Virginia Medicaid) and send the other payer information (i.e., Medicare) in the 2320 other payer loop. The AMT segments in the Medicare 2320 other payer loop are used to report Medicare adjudication results. Professional claims adjudication information should be sent at the 2430 service line level. CAS segments should be reported at the service line level because each line will be processed as a separate claim by Virginia Medicaid.

Refer to the applicable 837 Implementation Guide and Virginia Medicaid 837 Companion Guide (https://virginia.fhsc.com/hipaa/CompanionGuides.asp) for more information.

Note that an electronic claim can also be sent if you need to resubmit a crossover claim that originally denied, such as for other coverage, or if you need to adjust a paid crossover claim, such as to include patient liability.

Attachment (B)

How to Include the Medicaid Provider Number on an 837 Claim to Medicare

To avoid the problems and potential errors involved in cross-referencing a Medicare vendor number to a Medicaid provider number and to ensure your claim is adjudicated for the appropriate provider number, we recommend that you include your Medicaid provider number as a secondary identifier on the claim you send to Medicare.

The Medicaid provider number (Medicaid ID) should be sent as follows.

- For 837I claims, the Medicaid ID is sent in the 2010AA loop for the billing provider (billing provider secondary information).
- For 837P claims, the Medicaid ID is sent in the 2310B (claim level) and/or 2420A (service line level) loop for the rendering provider (rendering provider secondary information).

The reference (REF) segment identified in all of these loops supports the '1D' qualifier (REF01) for Medicaid ID (REF02). Refer to the applicable 837 Implementation Guide for more information.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Billing Provider Number	02 Last Name	03 First Name
04 Recipient ID Number	05 Patient's Account Number	06 Rendering Provider Number

1

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident/ Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid by Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only	24 NDC

2

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident/ Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid by Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only	24 NDC

3

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident/ Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid by Medicare

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4

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident/ Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid by Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only	24 NDC

25 Remarks

THIS IS TO CERTIFY THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THE CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

SIGNATURE DATE

INSTRUCTIONS FOR COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE INVOICE, DMAS - 30 - R 5/06

Purpose: A method for billing Medicare's deductible and coinsurance for professional services received by a Medicaid enrollee in the Virginia Medicaid program.

NOTE: This form can be used for four different procedures per Medicaid enrollee and rendering provider. A different form must be used for each Medicaid enrollee and rendering provider.

Block 01 **Billing Provider Number** - Enter the billing provider identification number used by Medicaid.

Block 02 **Recipient's Last Name** - Enter the last name of the patient as it appears from the enrollee's eligibility card.

Block 03 **Recipient's First Name** - Enter the first name of the patient as it appears from the enrollee's eligibility card.

Block 04 **Recipient ID number** - Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** - Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Rendering Provider Number** - Enter the rendering provider number.

Block 07 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation)

- Code 2 - No Other Coverage - If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- Code 3 - Billed and Paid - When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block. and enter the payment in Block 22.
- Code 5 - Billed and No Coverage - If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefit had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare)** - Mark type of coverage B only.

Block 09 **Diagnosis** - Enter the principal diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** - Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** - Check the appropriate box, which indicates the reason the treatment was rendered:

- ACC - Accident, Possible third-party recovery
- Emer - Emergency, Not an accident
- Other - If none of the above

Block 12 **Type of Service** - Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** - Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visit/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** - Enter the date of admission.

Block 16 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g. 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. Do not include Medicare payments.

Block 23 **Patient Pay Amount, LTC Only** - Enter the patient pay amount, if applicable.

Block 24 **NDC** - Enter NDC.

Block 25 **Remarks** - If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE ADJUSTMENT/VOID INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

1 ADJUSTMENT ☐ 092	VOID ☐ 094	2 BILLING PROVIDER NUMBER	A ICN/REFERENCE NUMBER	B REASON	C INPUT CODE
3 RECIPIENT'S LAST NAME	FIRST NAME	4 RECIPIENT'S I.D. NUMBER (12)	5 PATIENT ACCOUNT NUMBER	6 RENDERING PROVIDER NUMBER	

7 PRIMARY CARRIER INFO OTHER THAN MEDICARE	8 TYPE COV. MEDICARE	9 DIAGNOSIS	10 PLACE OF TREAT.	11 ACCIDENT/EMER. INDICATOR	12 TYPE SERV.	13 PROCEDURE CODE (5)	14 VISITS/UNITS STUDIES (3)	15 DATE OF ADMISSION	16 STATEMENT COVERS PERIOD FROM THRU
☐ 2 NO OTHER COV. ☐ 3 BILLED AND PAID ☐ 5 BILLED NO COV.	☐ B			☐ ACC ☐ EMER ☐ OTHER				MO. (2) DAY. (2) YEAR (2)	MO. (2) DAY. (2) YEAR (2) MO. (2) DAY. (2) YEAR (2)

17 CHARGES TO MEDICARE	18 ALLOWED BY MEDICARE	19 PAID BY MEDICARE	20 DEDUCTIBLE	21 COINSURANCE	22 PAID BY CARRIER OTHER THAN MEDICARE	23 PATIENT PAY AMOUNT LTC ONLY

24 NDC	

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THE CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

SIGNATURE DATE

INSTRUCTIONS FOR COMPLETION OF THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE ADJUSTMENT INVOICE, DMAS - 31

PURPOSE: To provide a means of making corrections or changes in claims that have been approved for payment. This form cannot be used for a follow-up of denied or pended claims.

EXPLANATION: To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.

Block 1: Adjustment / Void - Check the appropriate block.

Block 2: Billing Provider Number - Enter the billing provider identification number used by Medicaid. Also, enter the provider's name and address if not printed on the form.

Block 2 A: ICN/Reference Number - Enter the ICN/reference number, indicated on the remittance voucher, of the claim to be adjusted or voided. The adjustment or void can not be processed without this number.

Block 2 B: Reason - Leave blank

Block 2 C: Input Code - leave blank

Block 3 - 24: Please refer to DMAS - 30 for the completion of these blocks.

Remarks: This section of the invoice should be used to give a brief explanation of the change needed.

Signature: Signature of the provider or agent and the date signed are required.

Mechanics and Disposition:

The form may either be typed or legibly handwritten.